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February 9, 2010

John Hoopes
Caribou Memorial Hospital
300 South 3rd West
Soda Springs, ID 83276

Provider #131309

Dear Mr. Hoopes:

On **January 27, 2010**, a complaint survey was conducted at Caribou Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004471

An unannounced visit was made to the hospital on 1/27/10. During the complaint investigation, surveyors toured the facility with alertness to medication storage areas, interviewed staff, reviewed hospital policies, incident reports, and 6 patient records of patients who had diabetes.

Allegation #1: Nursing staff failed to follow physician orders for blood glucose testing on a diabetic patient.

Findings: In reviewing 6 medical records of patients who were identified to have a diagnosis of diabetes, 5 records documented blood glucose testing per physicians' order. One record documented an omission in blood glucose testing per physician's orders. This record involved a 53 year old female admitted on 12/11/09. A physician's order, dated 12/15/09 directed nursing staff to test the patient's blood sugar every 2 hours until stable and then every 3 hours. A physician's progress note, dated 12/19/09, indicated the patient's blood sugar had not been checked the previous night. A hospital incident report, dated 12/19/09, reported the omission of the blood sugar test at 3:00 AM and that the error had been found by nursing staff between 5:45 AM and 6:00 AM. The report indicated the physician had been contacted at 7:30 AM and the "patient or responsible party" had been notified of the error at 7:45 AM.

In response to physician orders, nursing staff rechecked the blood sugar at 7:30 AM and administered insulin per physician's orders. Nursing staff rechecked the blood glucose at 9:30 AM and again administered insulin per physician's orders. No additional errors were found related to testing of blood sugars.

During an interview on 1/27/10, a Nursing Supervisor was interviewed about the incident. He confirmed the incident occurred and stated nursing staff was counseled as to the importance of taking blood sugars. He stated that if he became aware of any repeat problems, he would not hesitate to counsel or correct nurses, if needed. He stated he was not aware of any other similar incident or trends or any trends at the hospital regarding failure to test blood sugars per physician's orders.

Although, it could be confirmed the incident occurred, the hospital had initiated appropriate corrective action and had a process in place to report and track errors and take corrective action.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: Nursing staff failed to administer insulin to a diabetic patient according to physician orders.

Findings: Six medical records were reviewed that included patients who were identified as having diabetes. Administration of insulin and/or other diabetic related medication appeared to be consistent with physician orders.

One record was for a 53 year old woman admitted on 12/11/09. A physician's order, dated 12/16/09 at 8:40 AM directed nursing staff to give a dose of 3 units of Humalog per 10 carbohydrates after eating. A second physician's order, dated 12/16/09 at 5:50 PM, directed nursing staff to use the patient's sliding scale in addition to the carbohydrate count. For a FSBS (fasting blood sugar) of 120-220 - give 5 units of Humalog; for FSBS of 220-320 - give 10 units of Humalog; for FSBS greater than 320 - give 20 units of insulin. The order did not clearly state to give insulin at times other than after eating.

A medication administration record, dated 12/17/09 at 3:00 AM documented a blood sugar of 279 and no corresponding insulin administration. When the Director of Nursing was asked during an interview on 1/27/10 at 5:25 PM why nursing staff did not give insulin for a blood sugar of 279, she responded that the order was written so that the insulin was only given after meals; the blood sugar was taken at 3:00 AM and there was no physician's order to give it at that time. She stated the nurse followed the order. She pointed out the physician wrote a clarification order later that morning (12/17/09 at 11:00 AM).

The clarifying order stated: "Clarification on FSBS" (fasting blood sugar) with sliding scale - check blood glucose levels at 3:00 AM, 9:30 AM, 11:30 AM, 2:30 PM, 5:30 PM, 9:30 PM, 11:59 PM. Give 5 units of Humalog if blood sugars are between 120-220. Give 10 units of Humalog if blood sugars are between 221-320. Give 20 units of Humalog if blood sugars are greater than 320. Give separate injections for carbohydrate counts after every meal at 9:00 AM, 1:00 PM, and 7:00 PM 3 units for every 10 carbohydrates. The new order made it clear that nursing staff was expected to administer insulin at times other than after meals.

Medication administration records indicated nursing staff administered insulin per physician's orders.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Nursing staff failed to properly store medications, leaving unmarked insulin bottles at the nurses station.

Findings: During an unnounced tour of the hospital's nursing station, there were no medication vials (labeled or unlabeled) observed to be in the nursing station or on the counters of the Medication Room. During an interview with the Director of Nursing on 1/27/10, she explained that medications were kept in individual patient bins in the Medication Room or in the refrigerator in the Medication Room, as appropriate.

It could not be determined that the hospital failed to properly label and store insulin.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As only one of the allegations was substantiated, but was not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Teresa Hamblin/sc

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